

**Please complete all editable sections of this form electronically and return by email to the address above**

Alternatively please print out and complete using BLACK INK and BLOCK CAPITALS and return by post to:  
New Zealand Dental Association, PO Box 28084, Remuera, Auckland 1541, New Zealand

**Section A – Membership start date and personal details**

If your application for membership of MPS is approved, it will be dated from the day following receipt of your application unless you specify a later start date in the box to the right: (DD/MM/YYYY)

<b>Title</b>		<b>Address for correspondence</b>	
<b>First name</b>			
<b>Middle name</b>			
<b>Surname</b>			
<b>Former name</b> (if any)			
<b>Date of birth</b> (DD/MM/YYYY)			
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Postcode</b> (zip or postal area)	
<b>Degrees and diplomas</b>		<b>Email address</b>	
<b>Dental school and country</b>		<b>Daytime telephone</b>	
<b>Month and year of graduation</b>		<b>Evening telephone</b>	
<b>Country of practice</b>		<b>Mobile number</b>	
<b>Professional registration number</b>		<b>Fax number</b>	

**IMPORTANT – Please read the following**

1. Failure to disclose full and accurate details about your previous history, practice and income may invalidate your membership which means you are not entitled to seek advice or assistance from MPS.
2. When completing the previous history section on pages 2 and 3 you must account for any gaps in your indemnity or insurance history during the last 10 years and also any break in clinical practice during the previous 2 years.
3. If you have had professional indemnity or insurance (other than from MPS) for any practice outside your stated country of practice you must obtain your case history to submit with this application.
4. If you have had previous indemnity or insurance we may approach your previous indemnity provider or ask you to obtain a copy of your claims history.
5. We will not assist with any matter arising from an incident pre-dating your MPS membership.
6. If you are leaving a claims made insurance contract, please ensure you have notified your previous provider of any adverse incident of which you are aware, that could become a claim. You should also check with the provider whether any closing payment is required to secure “run-off” cover for any future claim which may arise from an incident pre-dating your dental membership of MPS.

**Please note that signing the declaration on page 6 indicates acceptance of the following requirements:**

Members must keep MPS informed of their current address and any changes in their professional circumstances. Failure to notify us of any change of address, private practice income and scope of practice could result in the withdrawal of the benefits of membership and/or the termination of your membership. The benefits of MPS membership are granted at the discretion of Council and are subject to the terms and conditions of the MPS Memorandum and Articles of Association, as amended from time to time.

**Section B – Previous history (Please read the important information below)**

In this section you must include details of any matter in which you have been named or involved. Please include any pending, unresolved or closed issues, even those already reported to MPS. If necessary please continue your answers on the enclosed pages. Please note that failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

1. Have you had any professional indemnity/insurance before?  Yes (please go to Q2)  No (please go to Q3)

2. Please give the name of all other organisations and the dates during the last 10 years which you were a member or policyholder. If you were previously a member of MPS, please give your membership number and your full name at the time (if it has changed).

Organisation	From (DD/MM/YYYY)	To (DD/MM/YYYY)	MPS number	Full name	Other membership or policy number

3. Have you at any stage practiced without professional indemnity during the last 10 years (ie please exclude any period(s) protected by state, employer, insurer or MDO indemnity)? (If in doubt please indicate YES.) If you answer YES please confirm the dates and reasons.

Yes  No

4. Have there been any breaks in your clinical practice of more than 6 months in the last 2 years? (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reason for any gap. Please also provide details of any continuous professional development or refresher training that has been undertaken.

Yes  No

5. Have you ever previously been refused professional indemnity/insurance including a decline to renew or had it withdrawn/voided?

(If in doubt please indicate YES.) If you answer YES please provide a summary in your own words providing dates and reasons, including copies of any correspondence.

Yes  No

6. Have you had any non-standard terms or conditions including a non-standard subscription or premium imposed on your professional indemnity/insurance? If you answer YES please provide date and full details. (If necessary please continue on a separate sheet).

Yes  No

7. In the last 10 years, have you had any complaint(s) arising out of your professional practice which has not been resolved at a local level (ie within your own practice)? If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet).

Yes  No

If you have answered YES to any of the above questions please provide details as requested. Use the enclosed pages if needed and include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

**8. In the last 10 years have you been involved in any claim(s) for compensation or damages arising out of your professional practice regardless of the outcome?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet).

Yes  No

**9. Are you aware of any incident(s) that might become a claim?** If you answer YES please provide full details of the incident(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate sheet).

Yes  No

**10. Have you ever been the subject of a disciplinary inquiry or had practice privileges refused/withdrawn/made conditional by a health care provider?** If you answer YES please provide full details of the incident(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate sheet).

Yes  No

**11. Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the case. (If necessary please continue on a separate sheet).

Yes  No

**12. Have you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expired convictions, or minor road traffic offences that did NOT involve alcohol or drugs)** If you answer YES please provide full details. The details must include: date of incident, full details of the offence, the final outcome or current position and was this reported to the regulatory body. (If necessary please continue on a separate sheet).

Yes  No

**13. Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership?** (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessary please continue on a separate sheet).

Yes  No

If you have answered YES to any of the above questions please provide details as requested. Use the enclosed pages if needed and include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

**Section C – Practice details**

If you are registered to practise in any other Country please state which:

Will all your professional practice be carried out in the Country in which you are applying for membership?

Yes  No If No, please provide Country and full details (if necessary please continue on a separate sheet).

Will you be involved in treating or providing advice to patients outside of the Country in which you are applying for membership? (eg telemedicine)

Yes  No If Yes, please provide Country and full details (if necessary please continue on a separate sheet).

Please indicate if you are a member of one of the following organisations:

NZDA  NZDTA  NZDHA  CDTA

**IMPORTANT** – Please see end of application form for MPS subscription categories and indicate the grade code most appropriate for your practice: (eg D2)

If you are unsure of the membership category applicable to you, please provide a summary of the work you carry out (ie a detailed scope of practice).

**Section D – Limited clinical activity**

If you wish to apply for a part time subscription because your clinical activity is limited please tick the box:

My current clinical activity is no more than 10 hours/week (500 hours/year)

My current clinical activity is no more than 20 hours/week (1000 hours/year)

**Additional space for answers**

Please clearly indicate the question number that you are providing details for below.

**IMPORTANT – Your Personal Information and Data**

When interacting with MPS, you may choose to give MPS information about your criminal convictions and offences (including alleged offences), your health, race, ethnic origin, sex life, sexual orientation and trade union membership (“Special Category Data”). This happens where that information is relevant to your membership or the actual or potential provision of advice, assistance or indemnity. We may also receive Special Category Data about you from others in connection with membership or advice, assistance or indemnity (eg from a complainant, claimant, witness, expert, court or regulator).

To find out more about how we collect, use and handle your data including Special Category Data, please see the Privacy Statement on our website [dentalprotection.org/privacy](http://dentalprotection.org/privacy)

When you tick the box below, you expressly consent to MPS processing your Special Category Data for the purposes of providing you with membership and its benefits (including assistance and indemnity).

**I consent**

You may withdraw consent to such processing by contacting MPS, but if you do so we will no longer be able to provide you with membership and its benefits.

**IMPORTANT – Please read, sign and add the current date below**

By signing and returning this form, you agree and confirm that:

- i. You wish to apply for membership of MPS subject to the Memorandum and Articles of Association.
- ii. You understand that any failure to disclose full and accurate details may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.
- iii. You understand that membership is not conferred automatically and is subject to approval by MPS.
- iv. You acknowledge that any subscription payments made are subject to verification and that acceptance of a payment by MPS does not of itself confirm membership and/or entitlement to request benefits.
- v. You will inform us if your personal circumstances or scope of practice change.
- vi. We may seek information from other professional defence organisations, insurance companies, employers, and/or other third parties in respect of membership and that they may release to us such information.
- vii. For the purposes of New Zealand law and the New Zealand Privacy Act 2020, we may obtain, process, retain and transfer your personal information as set out in the Privacy Statement on our website [dentalprotection.org/privacy](http://dentalprotection.org/privacy)

Date

Please note this must be the current date

Tick here if you are submitting additional sheets or correspondence.

In order to provide you with the best possible service we would like to inform you of other products and services offered by us that we believe may be of interest to you. To opt-in to receive such information, either via post or email, please tick here.

You can contact us to update your marketing preferences.

**Please tell us why you have chosen MPS – Your comments are important to us, please tick below**

- |    |                          |   |
|----|--------------------------|---|
| 1. | <input type="checkbox"/> | Personal recommendation                                     |
| 2. | <input type="checkbox"/> | Competitive subscription rates                              |
| 3. | <input type="checkbox"/> | MPS membership co-ordinator, please provide their initials: |
| 4. | <input type="checkbox"/> | Group arrangement   |
| 5. | <input type="checkbox"/> | Dissatisfaction with previous organisation                  |
| 6. | <input type="checkbox"/> | Other (please provide details)                              |



**Dental Protection – New Zealand**

New Zealand Dental Association  
 PO Box 28084  
 Remuera  
 Auckland 1541

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 F 64 9 580 0010  
[dentalprotection.org](http://dentalprotection.org)  
[jill@nzda.org.nz](mailto:jill@nzda.org.nz)

DENTISTS AND ORAL MAXILLOFACIAL SURGEONS – NZDA MEMBERS	GRADE
Standard rate: Full-time practice	YD3
Standard rate: Part-time practice (see note 1)	DPT
Standard rate: Extended procedures (see note 2)	YDO
Oral surgeons, and oral and maxillofacial surgeons: Full-time	DZO
Oral surgeons, and oral and maxillofacial surgeons: Part-time (see note 1)	POM
Post graduate students: Full-time	NDS
Defence force: Full-time	EIS
Government health employees: Full-time	EGH
Dental school staff: Full-time	EDS
Corporate membership	CFU

DENTISTS AND ORAL MAXILLOFACIAL SURGEONS – NON NZDA MEMBERS	GRADE
Standard rate: Full-time practice	NNZ
Standard rate: Part-time practice	DDS
Standard rate: Extended procedures (see note 2)	NNE
Oral surgeons, and oral and maxillofacial surgeons: Full-time	NNO
Oral surgeons, and oral and maxillofacial surgeons: Part-time (see note 1)	NPO
Post graduate students: Full-time	DND
Defence force: Full-time	DEI
Government health employees: Full-time	DEG
Dental school staff: Full-time	DED
Graduate members	DZ3
Student membership	

### IMPORTANT NOTES

1. Part-time is defined as less than 500 hours per annum or less than 10 hours per week. The definition for part-time is based on the hours worked and not the type of work either clinical or non-clinical.
2. Extended procedures include botox, collagen and similar cosmetic facial procedures carried out in the orofacial complex and associated structures within the scope of the practitioner's education, training and competence. The part-time rate does not apply to extended procedures. Cover for these procedures is already included in the Oral and Maxillofacial rate.

<b>DENTAL HYGIENISTS/DENTAL THERAPISTS/CLINICAL TECHNICIANS – FULL-TIME PRACTICE</b>		<b>GRADE</b>
Dental hygienist		OTH
Dental therapist		OTS
Clinical dental technicians (CDTA member)		CDT
Clinical dental technicians (non-CDTA member)		DEC
Oral health therapist		OH1

<b>DENTAL HYGIENISTS/DENTAL THERAPISTS/CLINICAL TECHNICIANS – PART-TIME PRACTICE</b> (see note 1)		<b>GRADE</b>
Dental hygienist		PD1
Dental therapist		PD2
Clinical dental technicians (CDTA member)		PDT
Clinical dental technicians (non-CDTA member)		CDP
Oral health therapist		OH2

**IMPORTANT NOTES**

1. Part-time is defined as less than 1000 hours per annum or less than 20 hours per week. The definition for part-time is based on the hours worked and not the type of work either clinical or non-clinical.



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